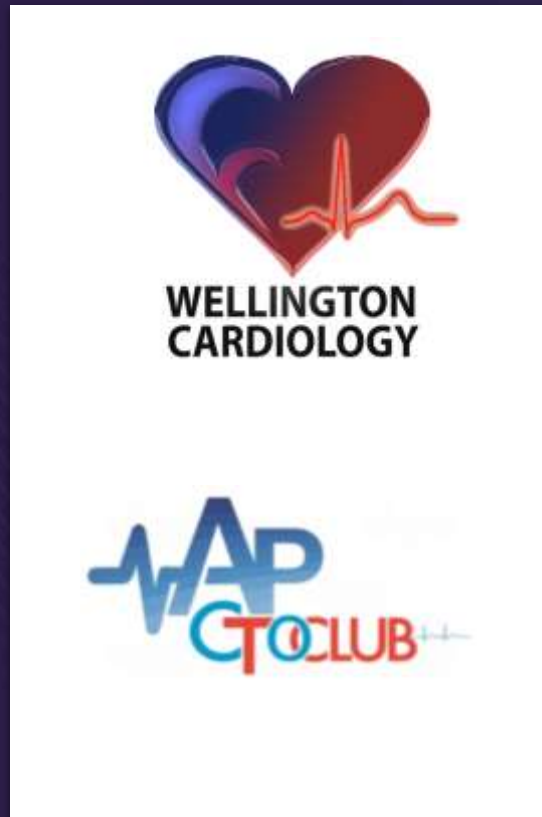


Taped Case #1



Scott Harding
Department of Cardiology
Wellington Hospital

Disclosure Statement of Financial Interest

Within the past 12 months, I or my spouse/partner have had a financial interest/arrangement or affiliation with the organization(s) listed below.

Affiliation/Financial Relationship

- Grant/Research Support
- Consulting Fees/Honoraria

Company

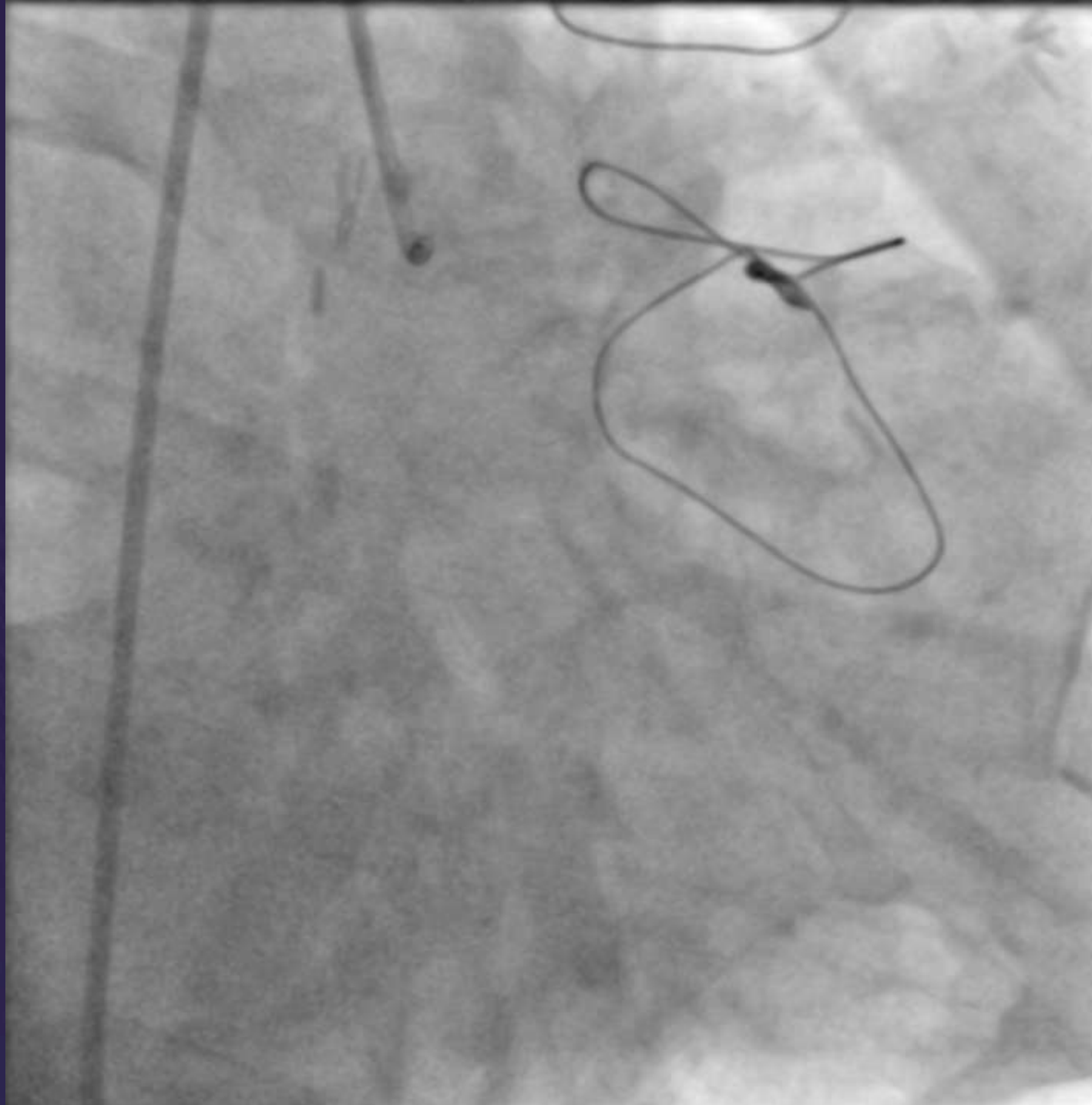
- Asahi Intecc
- Abbott Vascular, Boston Scientific, Asahi Intecc, Teleflex Medical

CASE PREVIEW

- 70 year old male presenting with limiting stable angina on 3 anti-anginal agents
- Previous CABG (LIMA to the LAD, SVG to the PDA, SVG to RCA) 2003
- Previous anterior MI
- Paroxysmal AF
- Hypertension and dyslipidaemia
- Anteroseptal Q waves
- Echocardiogram: EF 37%. Severe anterior hypokinesis, mild hypokinesis in RCA territory
- Hb 137 g/L, eGFR 58 ml/min/1.73m²

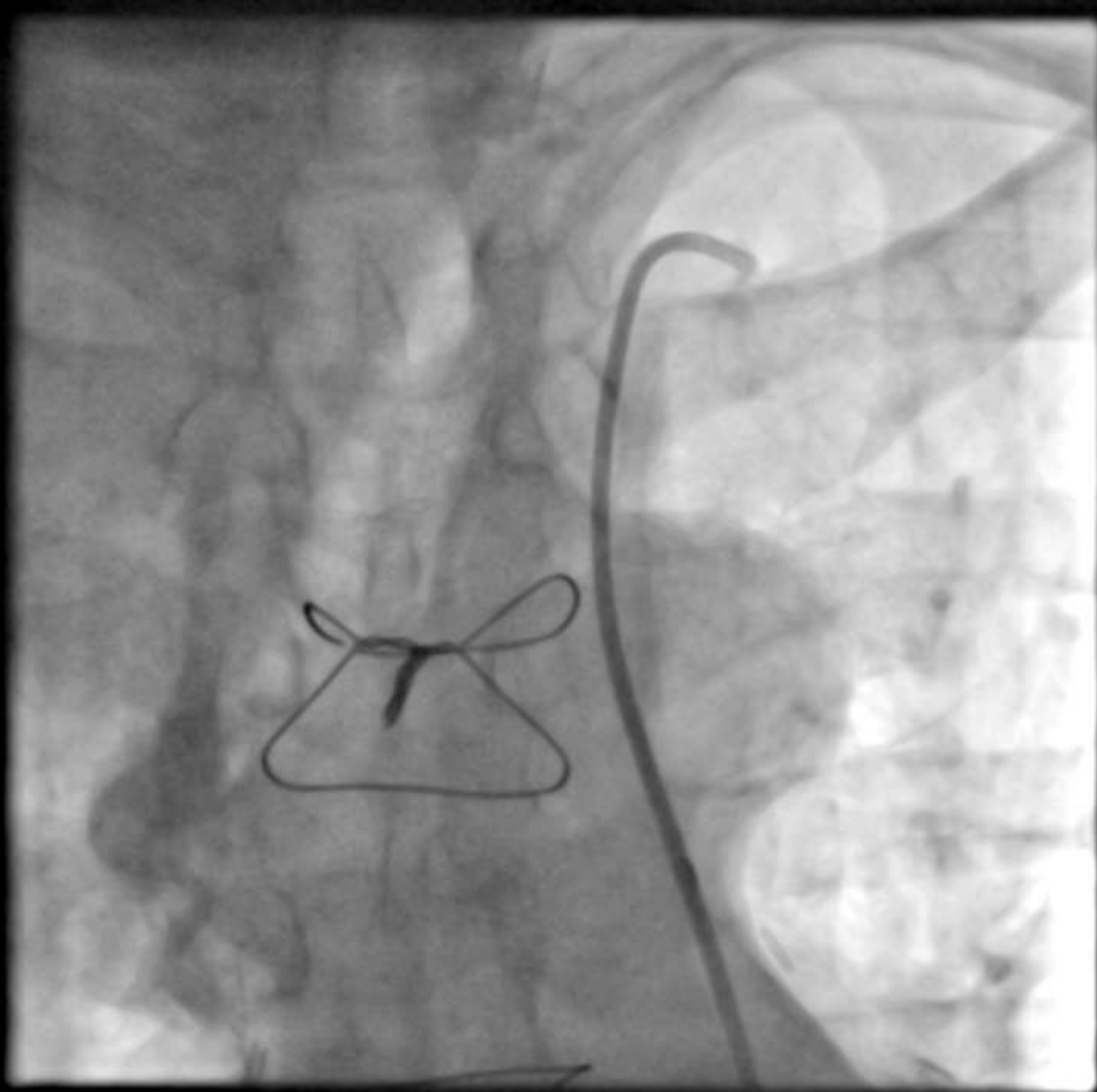
ANGIOGRAPHY

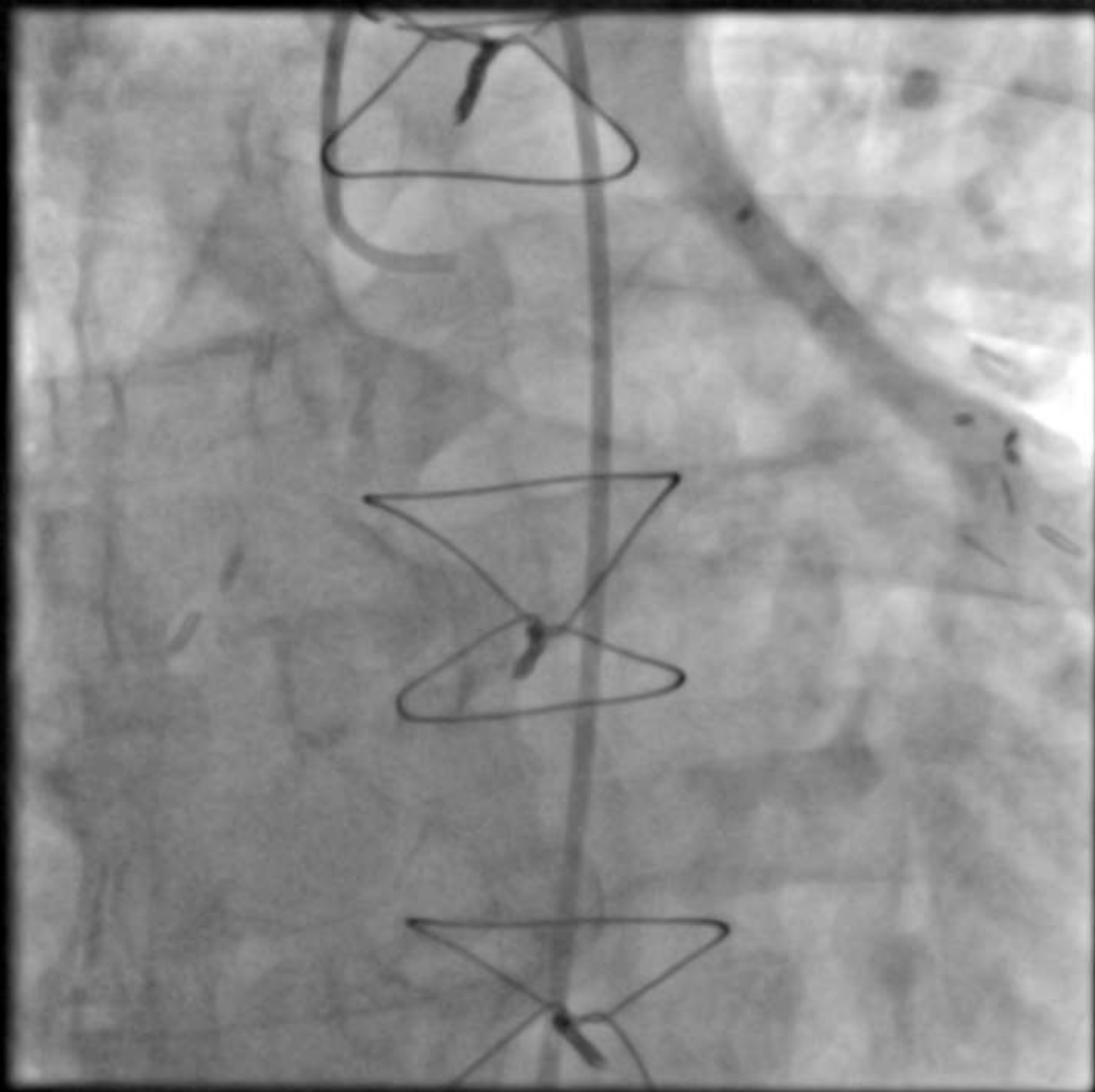


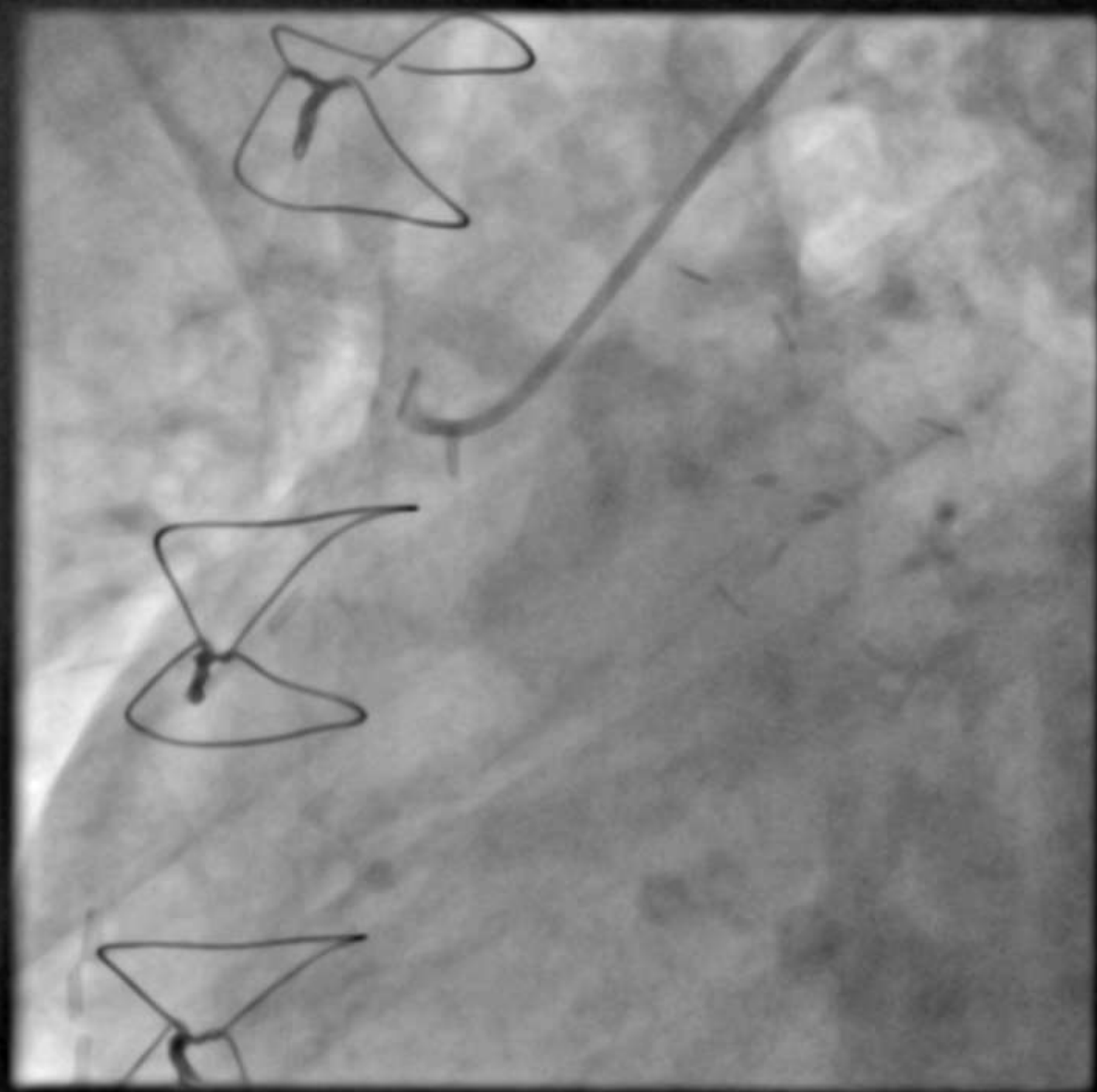






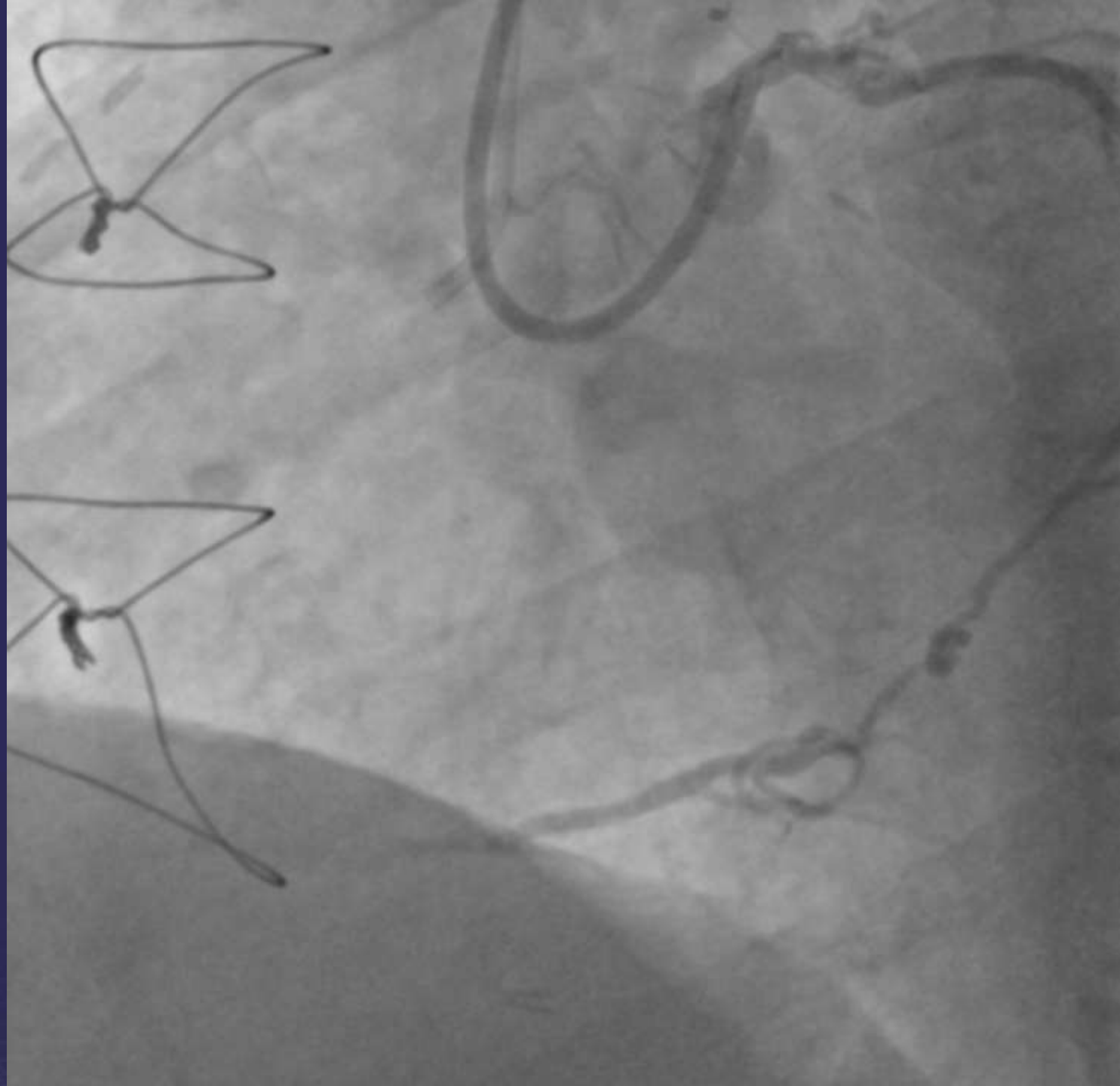




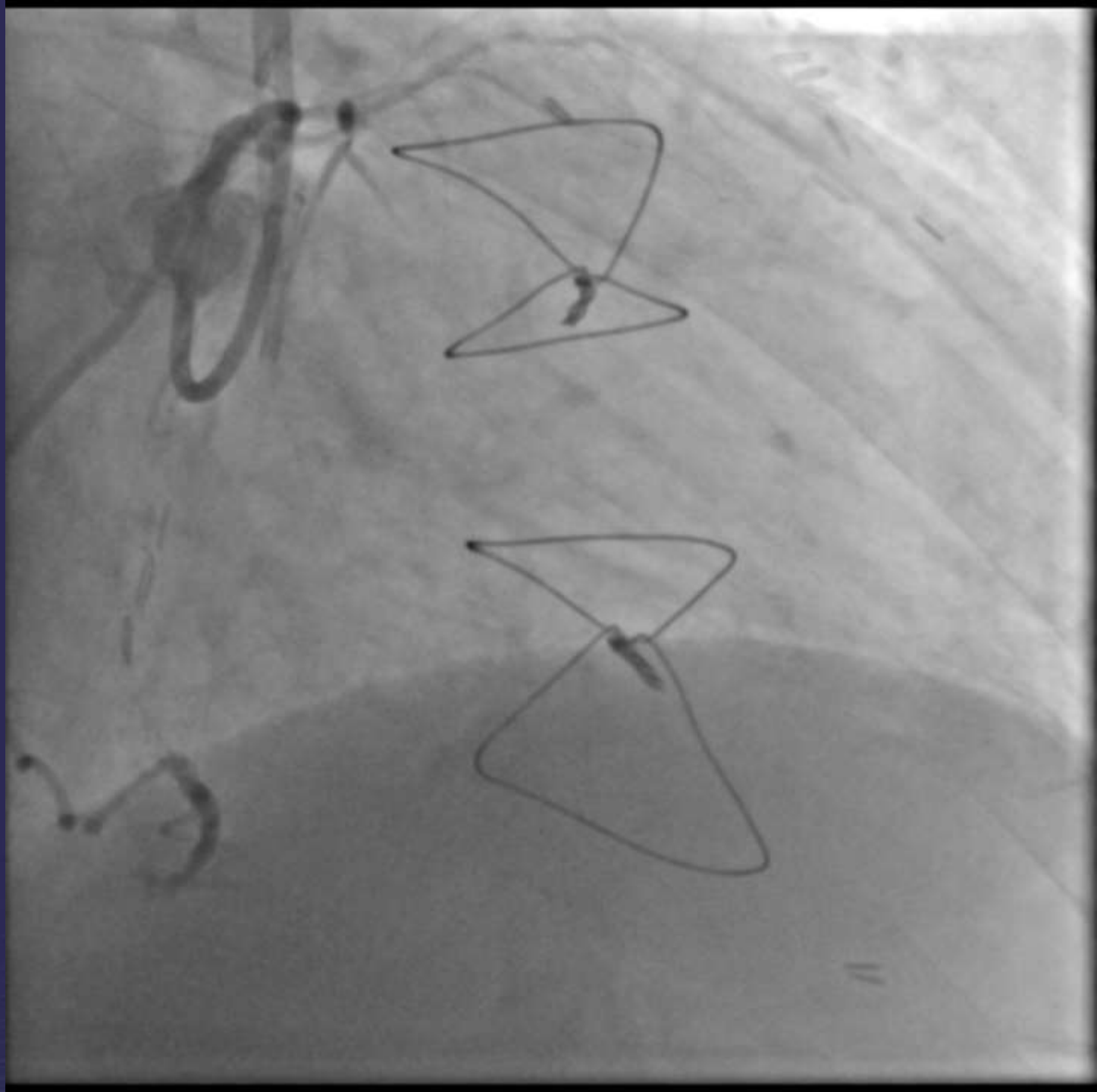


Dual angiography

- Unambiguous proximal cap
- Length >20 mm
- Good quality distal vessel
- Interventional collateral from the Cx to the PLV



Dual angiography

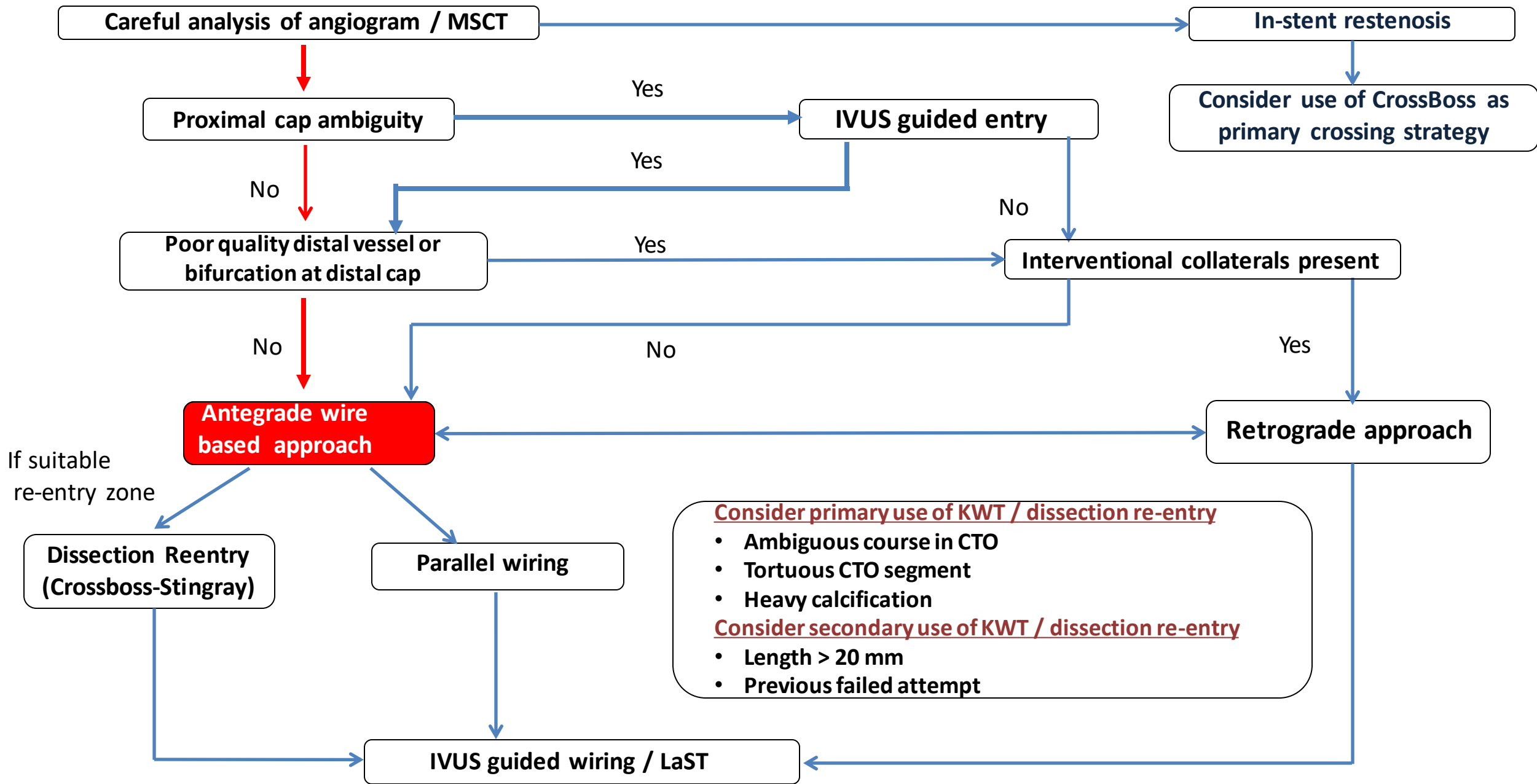


DISCUSSION I

- RCA occluded since 2003
- J-CTO score 3
- Moderate to severe LV impairment with LVEDP at time of procedure of 19 mm Hg

? Initial best approach

- AWE
- Retrograde
- ADR



Consider stopping if >3 hours, 3.7 x eGFR ml contrast, Air Kerma > 5 Gy unless procedure well advanced

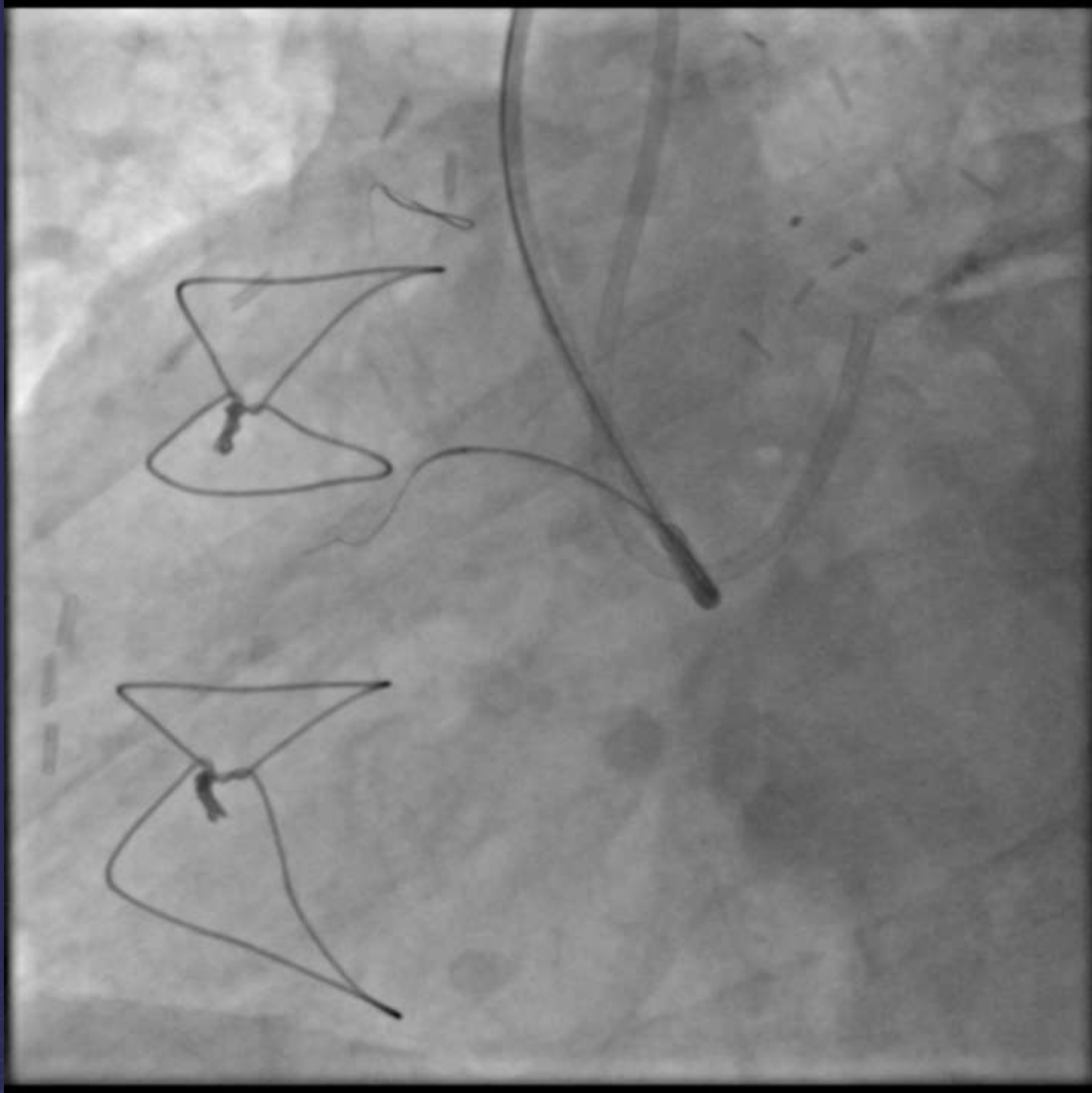
CTO Case

7F AL0.75

Corsair Pro 135 cm

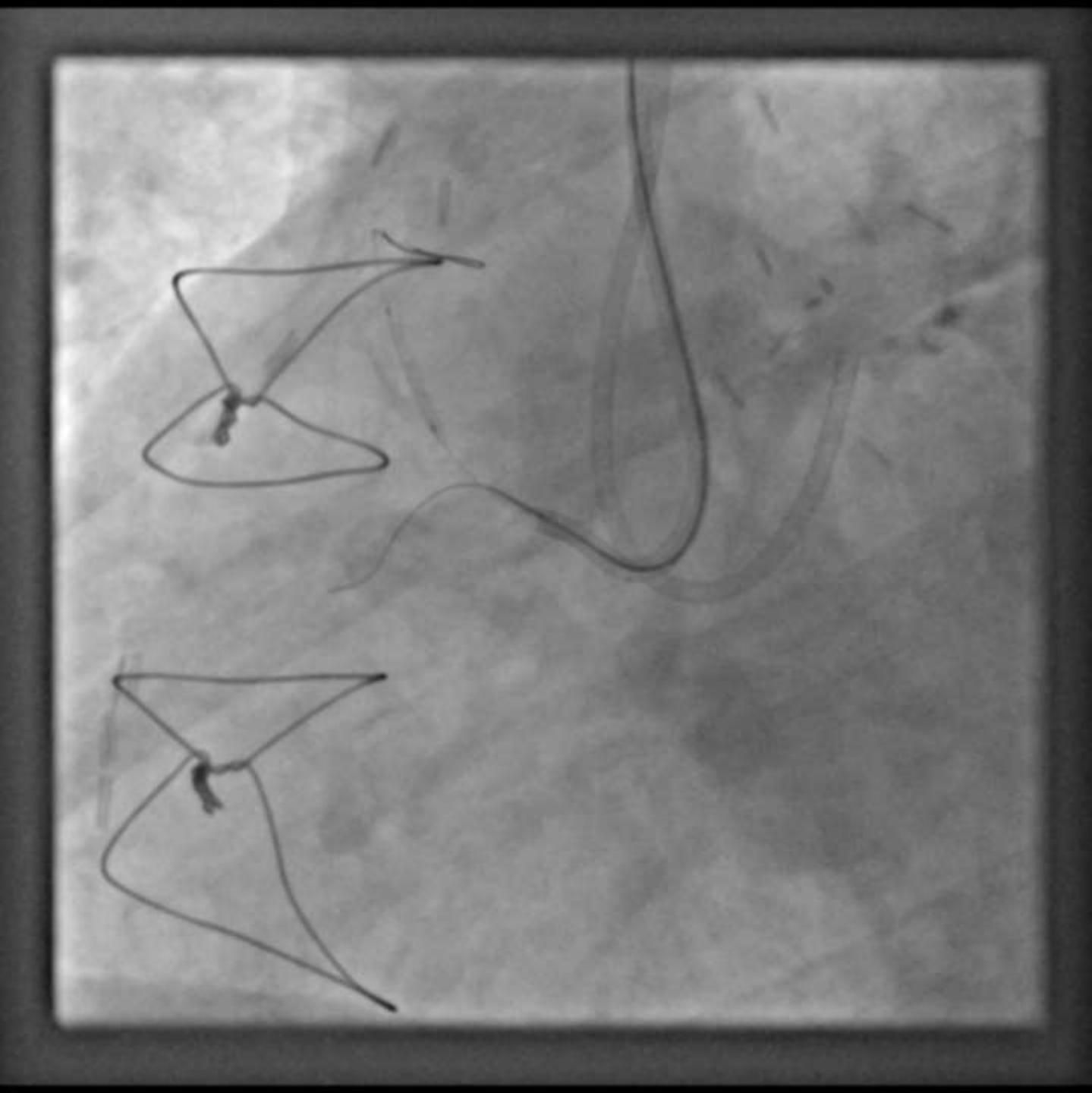
XT-A down to proximal
cap

Difficulty advancing
Corsair Pro



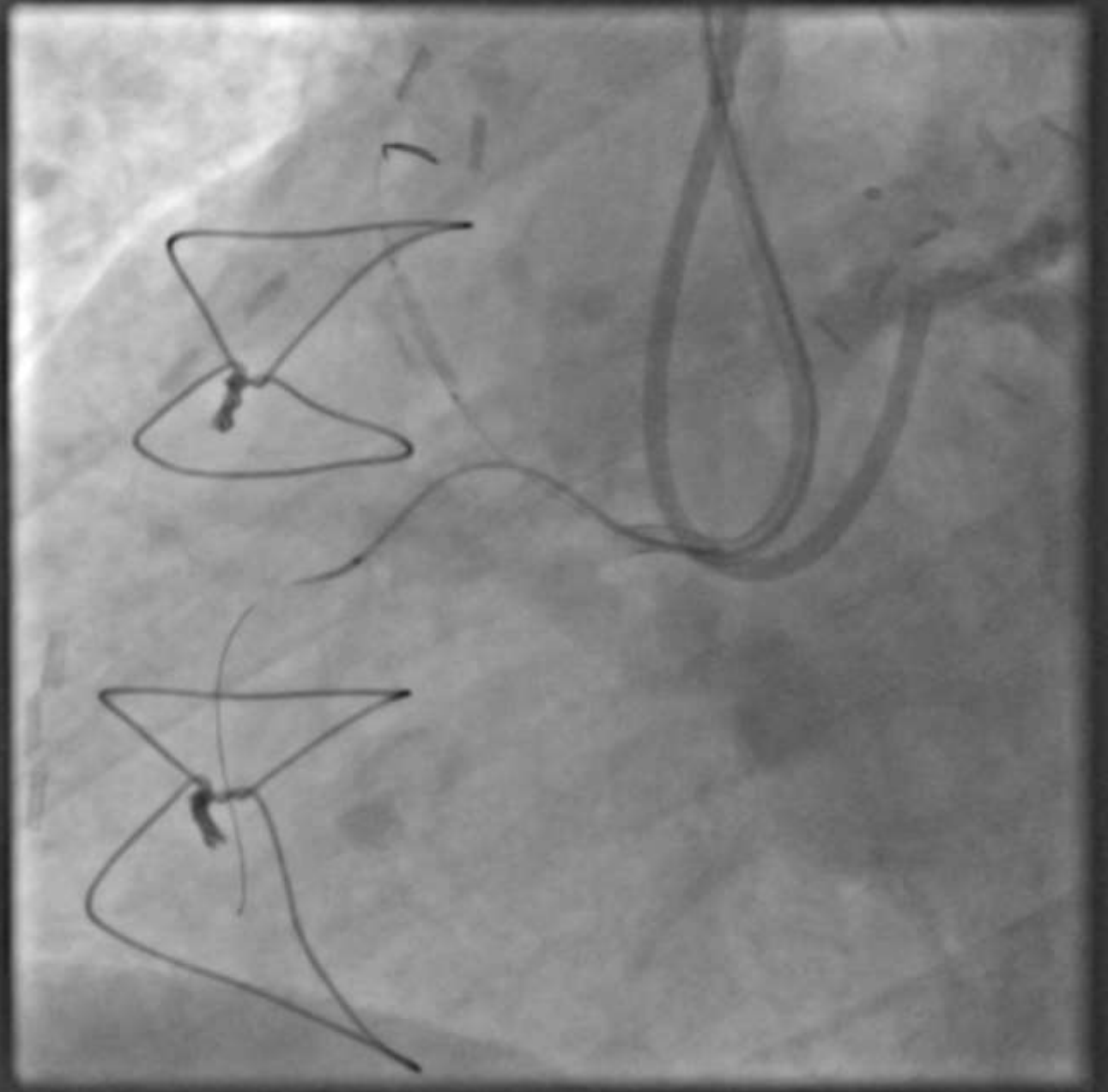
CTO Case

Anchor balloon to
increase guide support



CTO Case

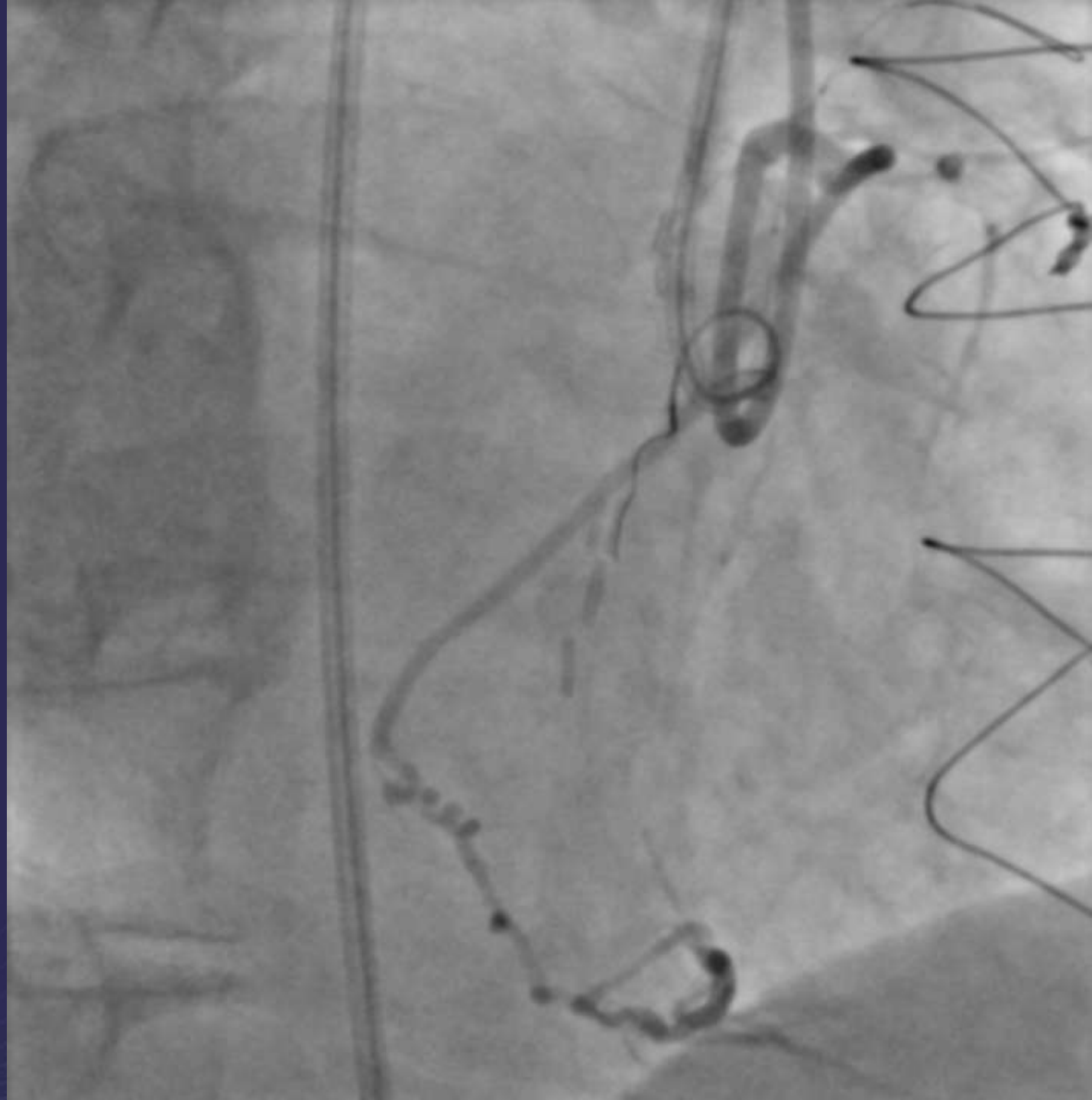
Needed to dilate
proximal vessel with
1.0, 1.25 and 2.0 mm
balloons to allow
advancement of the
Corsair Pro
Fielder XT-A into branch



CTO Case

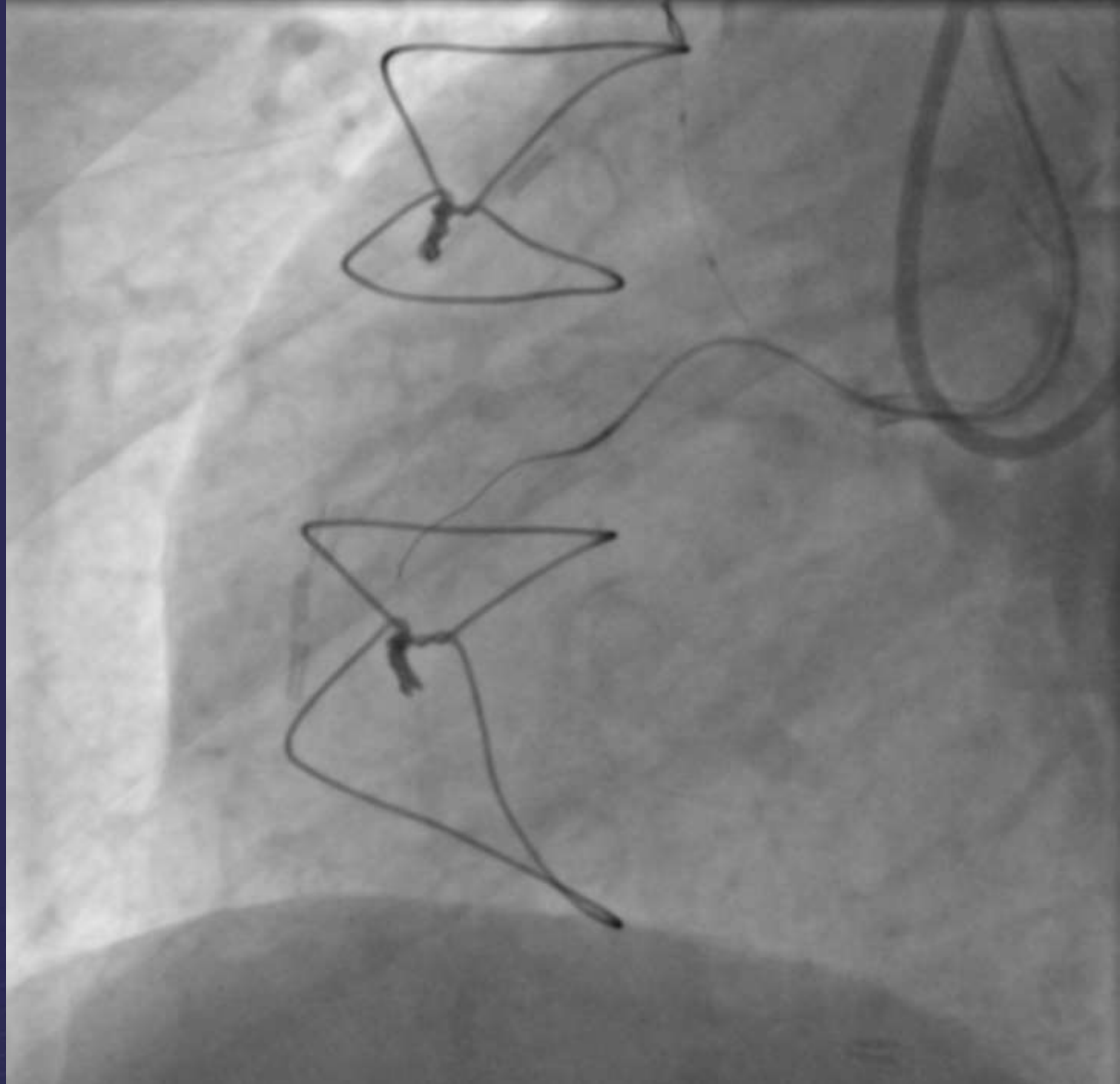
Escalation to GAIA 2nd
Next

Wire looks on course in
RAO view



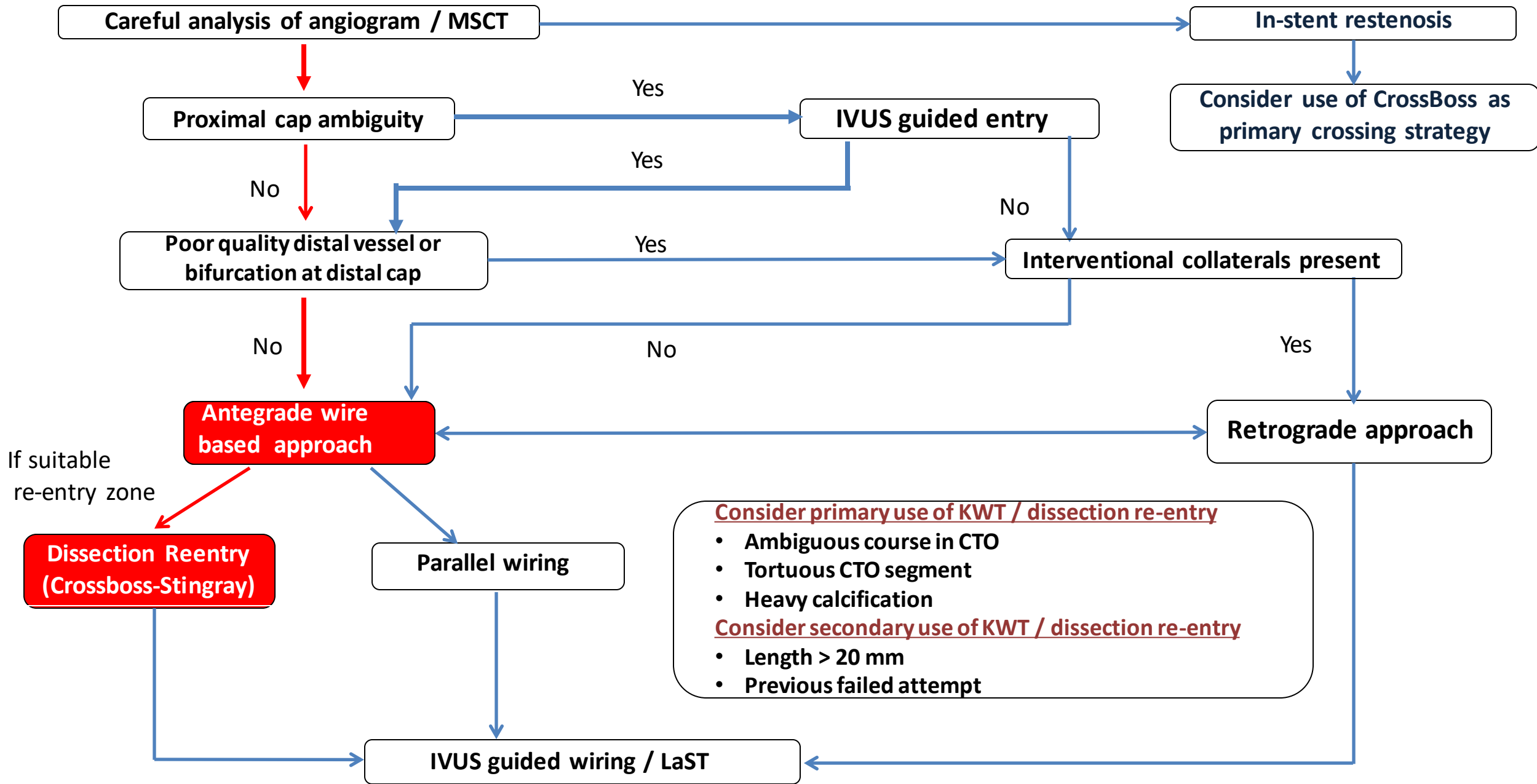
CTO Case

But wire appears on the outside in the LAO view



DISCUSSION II

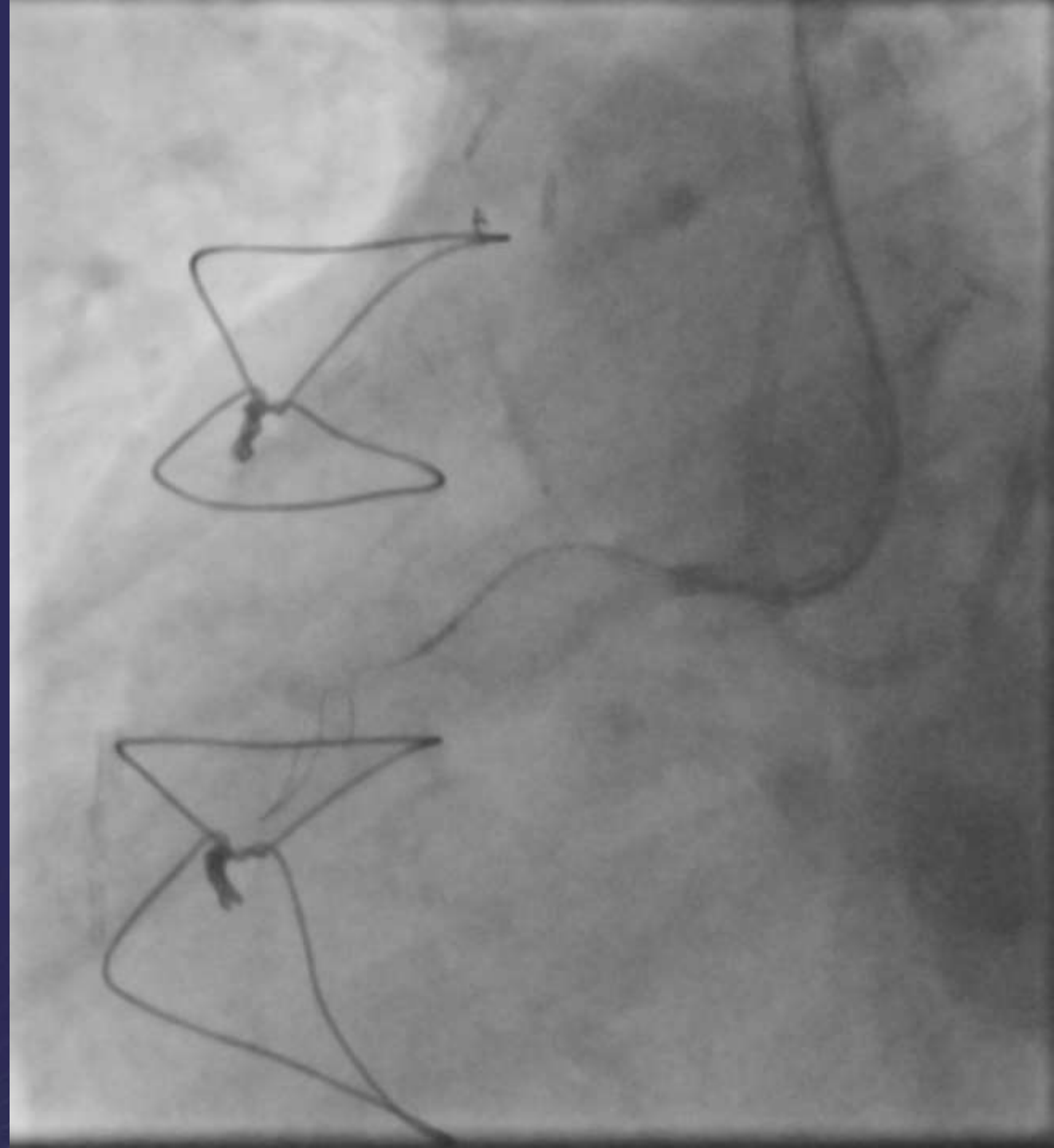
- 65 min into the procedure, 75 ml contrast used, 0.8 Gy radiation
- What now?
 - Redirect wire
 - Parallel wire
 - Switch to retrograde
 - Switch to ADR



Consider stopping if >3 hours, 3.7 x eGFR ml contrast, Air Kerma > 5 Gy unless procedure well advanced

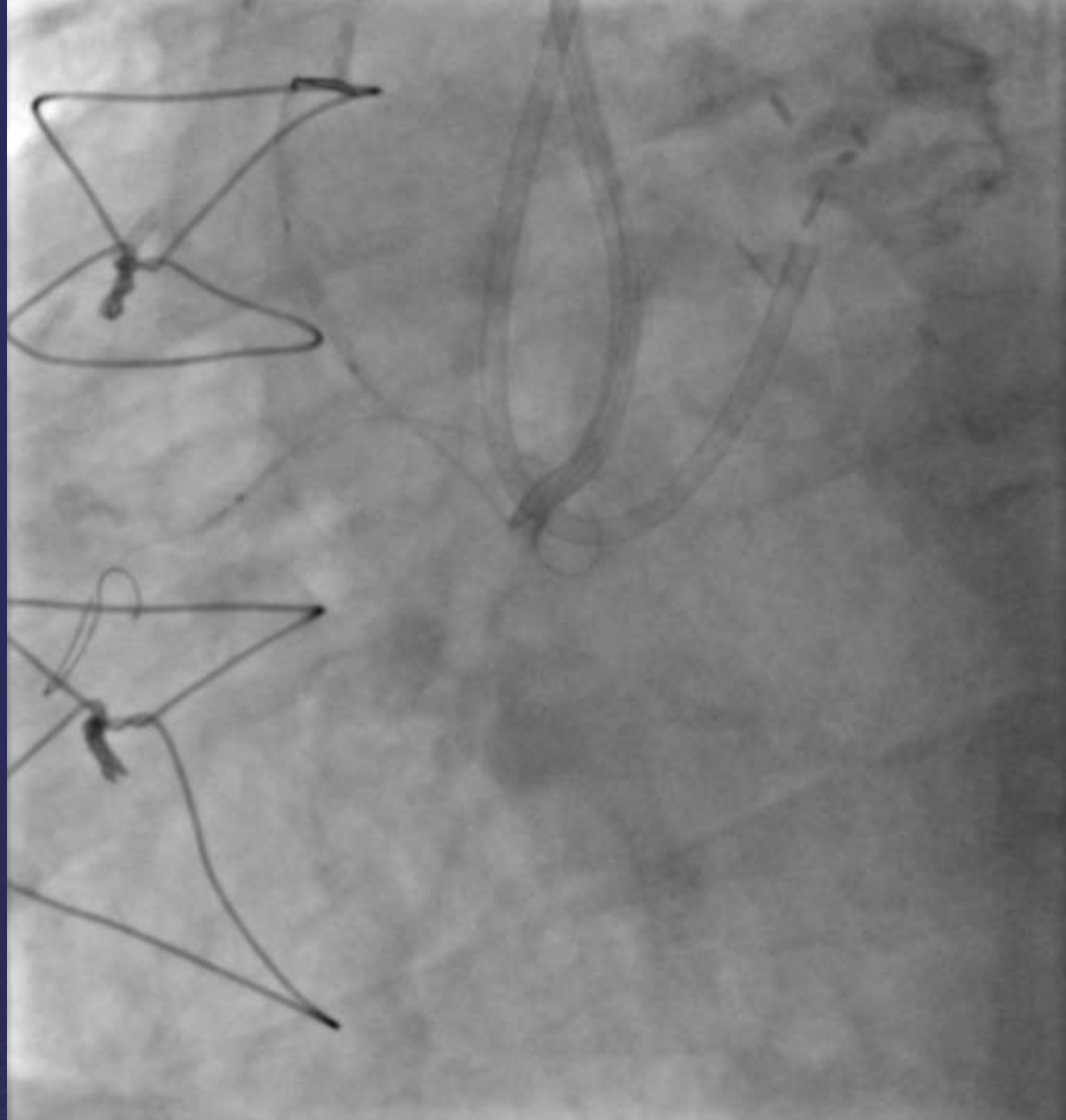
CTO Case

- Switch to ADR
- Knuckle with Pilot 200



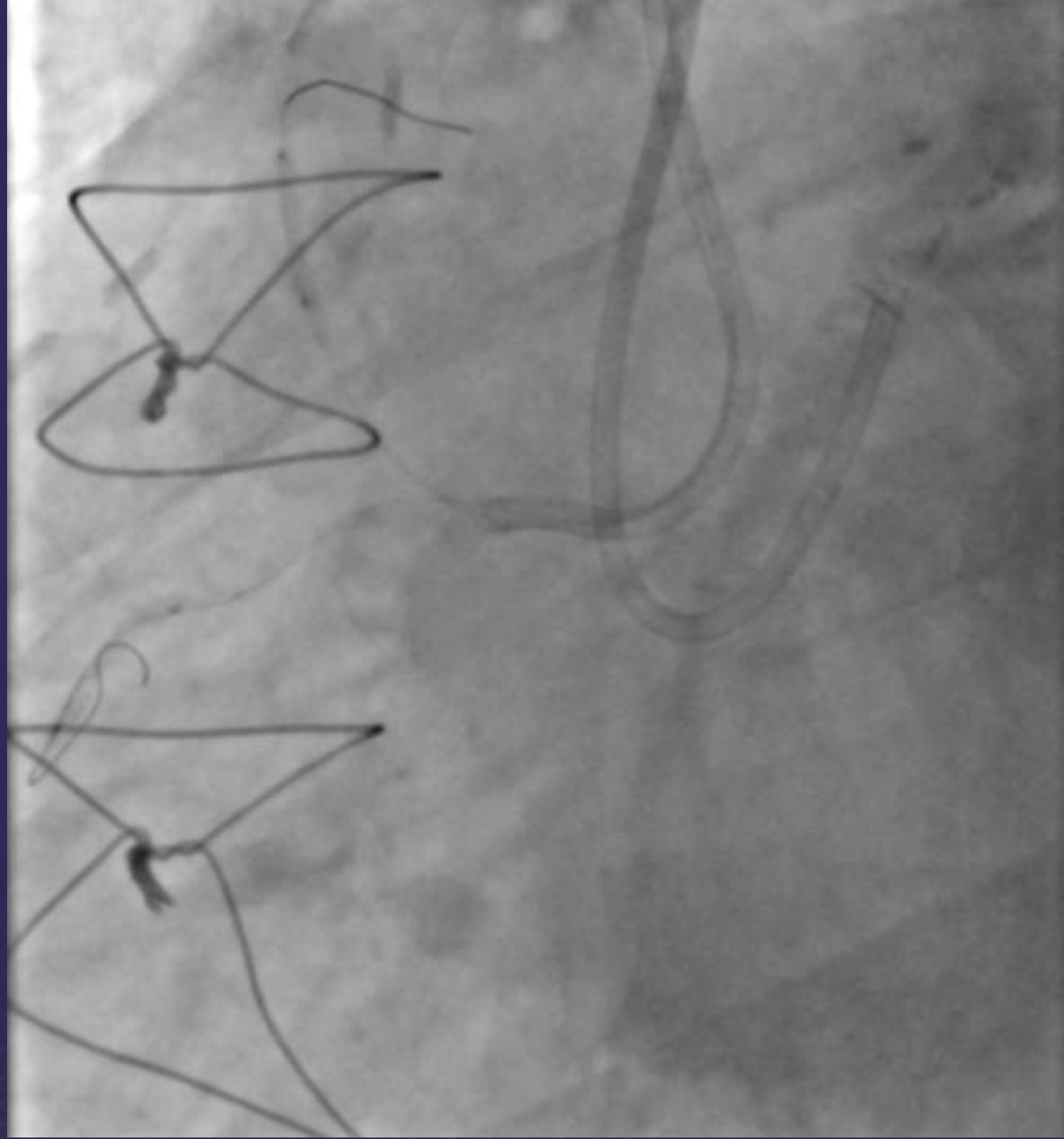
CTO Case

Unable to advance knuckle or
Corsair Pro



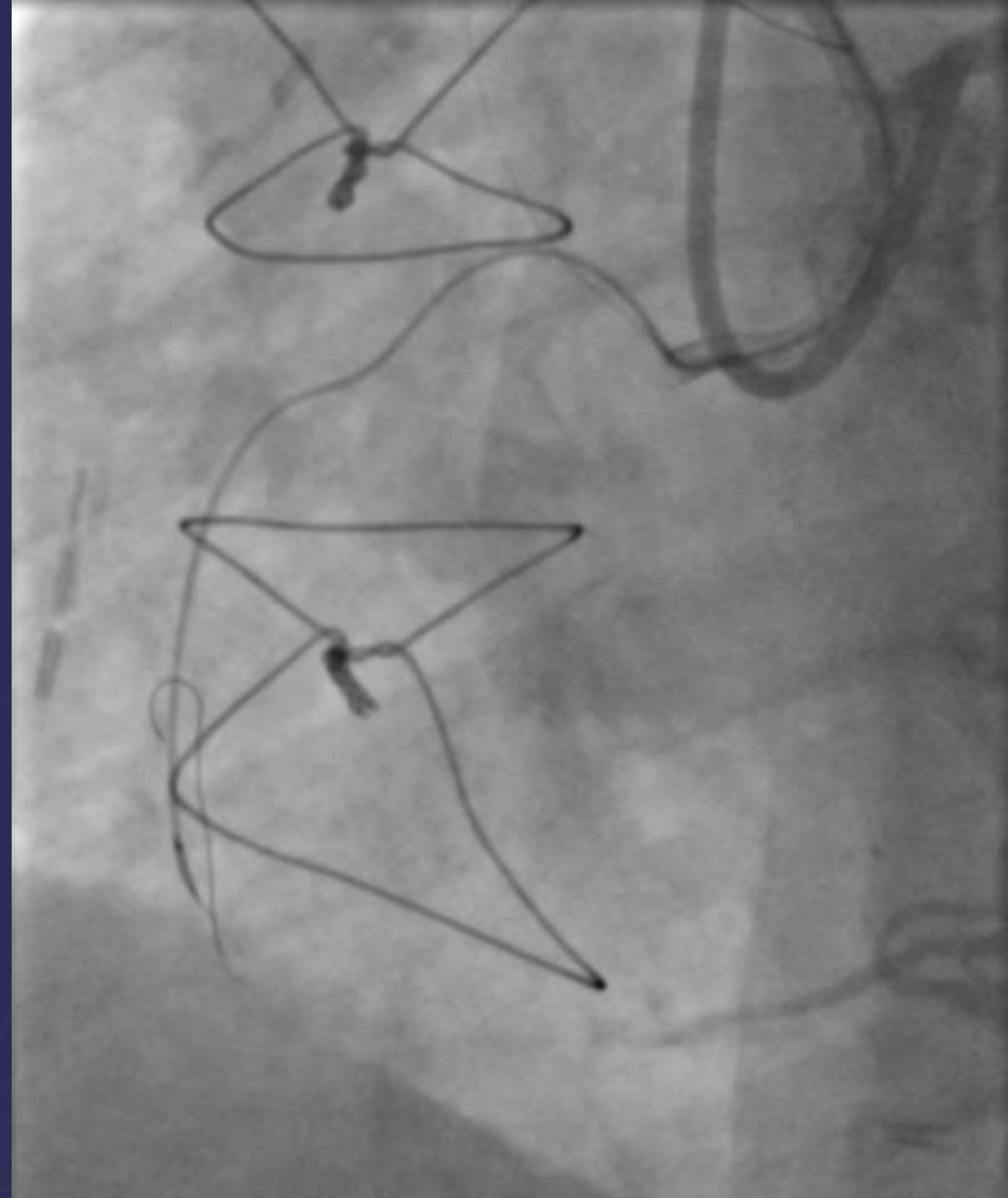
CTO Case

Serial dilation with 1.0, 1.5
and 2.0 balloons



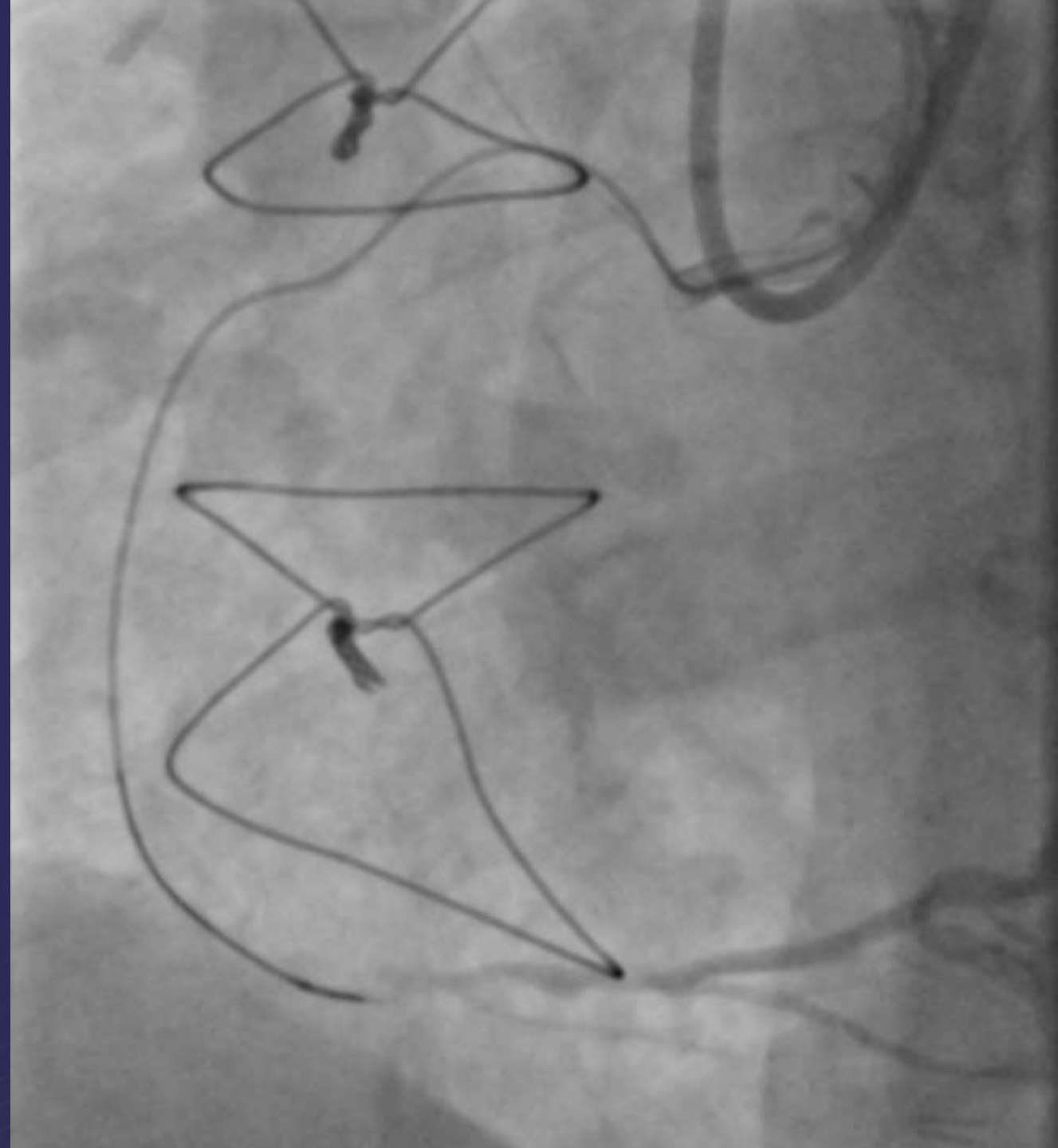
CTO Case

Knuckle wire and Corsair Pro advanced just proximal to the distal landing zone



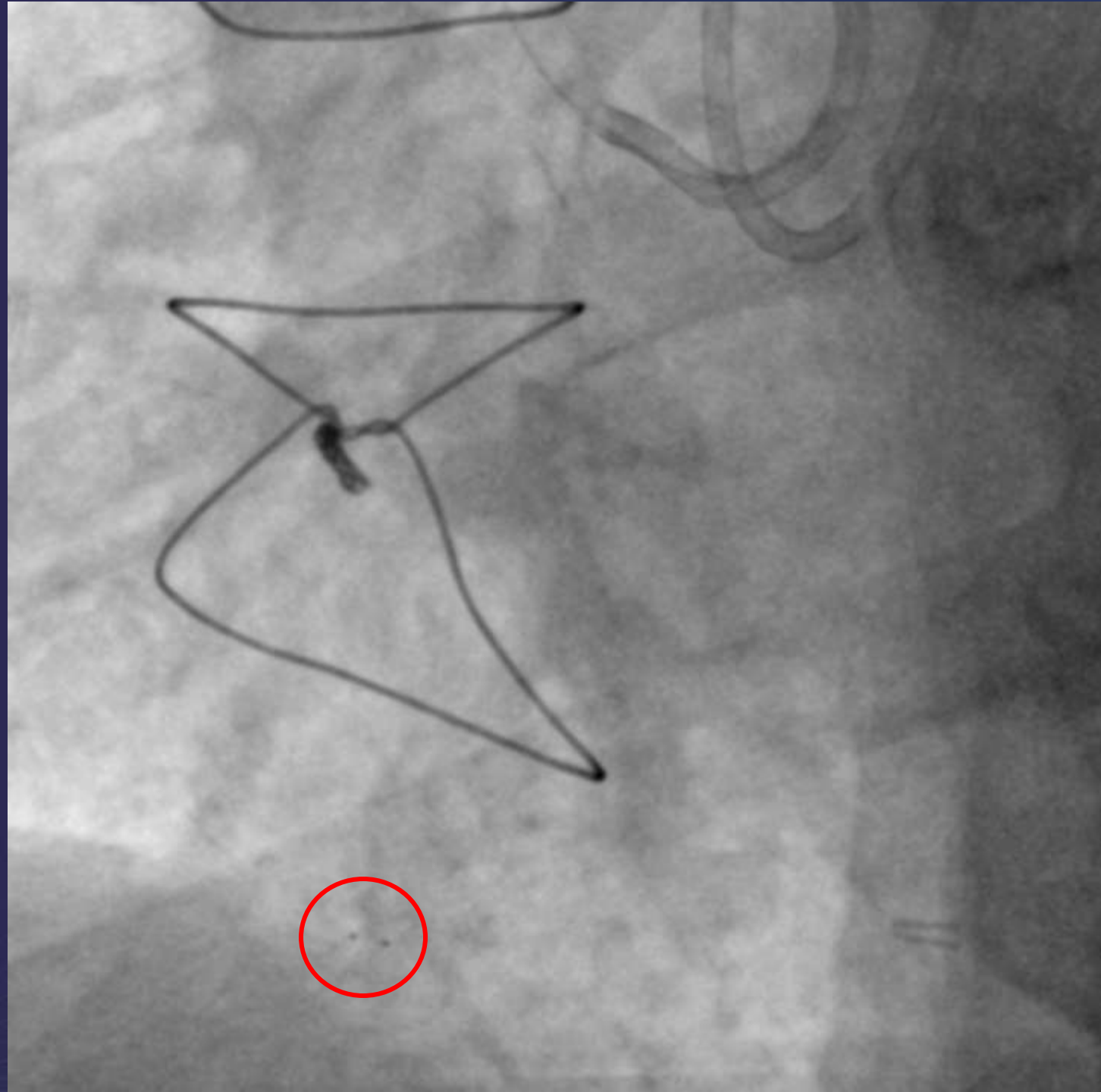
CTO Case

- Knuckle removed and Miracle 12 advanced to re-entry zone
- Corsair Pro advanced over Miracle 12
- Corsair exchanged for Stingray balloon



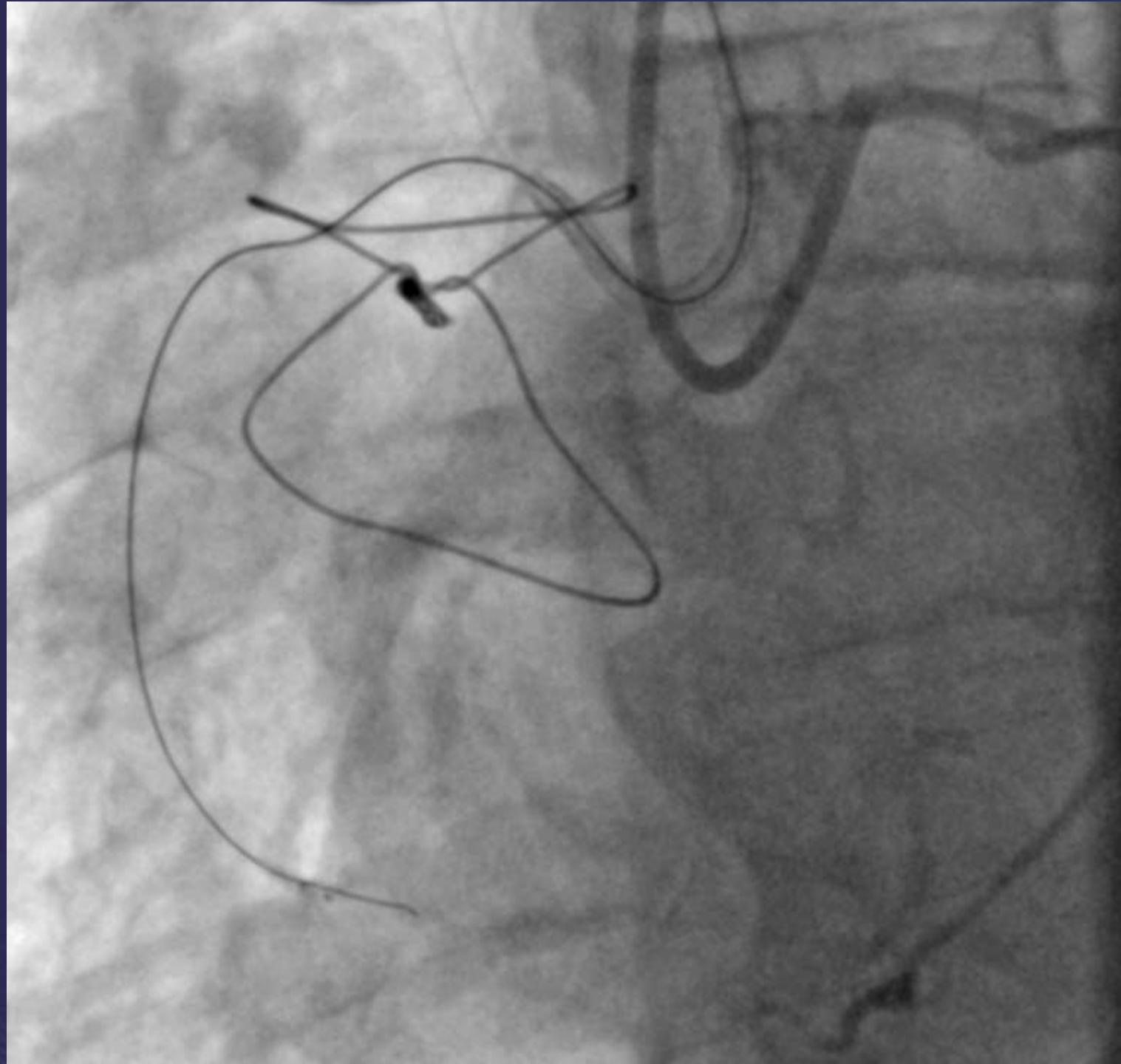
CTO Case

Stingray balloon in distal landing zone inferior to the vessel



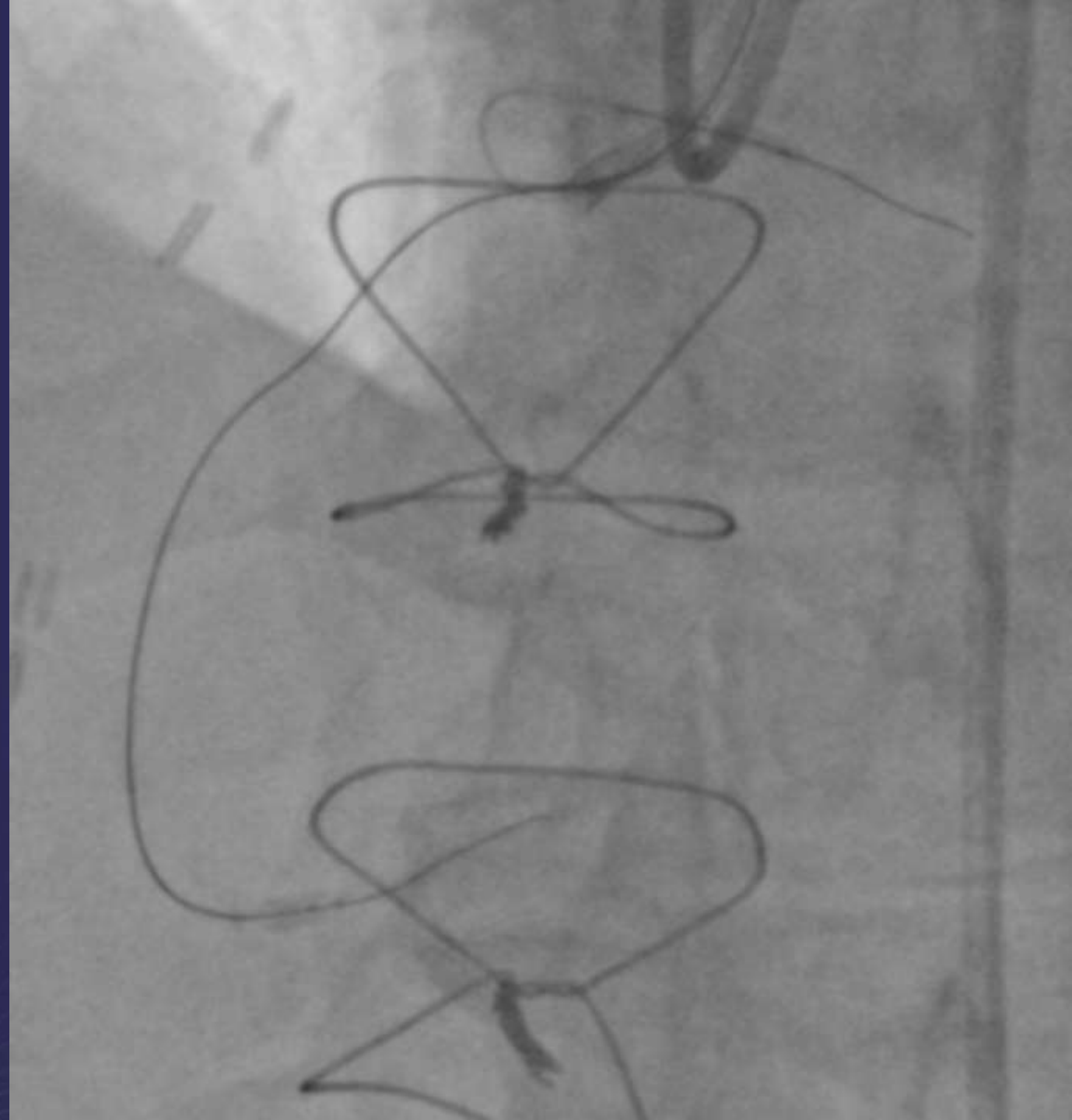
CTO Case

Stick superiorly through the proximal port with GAIA 3rd
Next



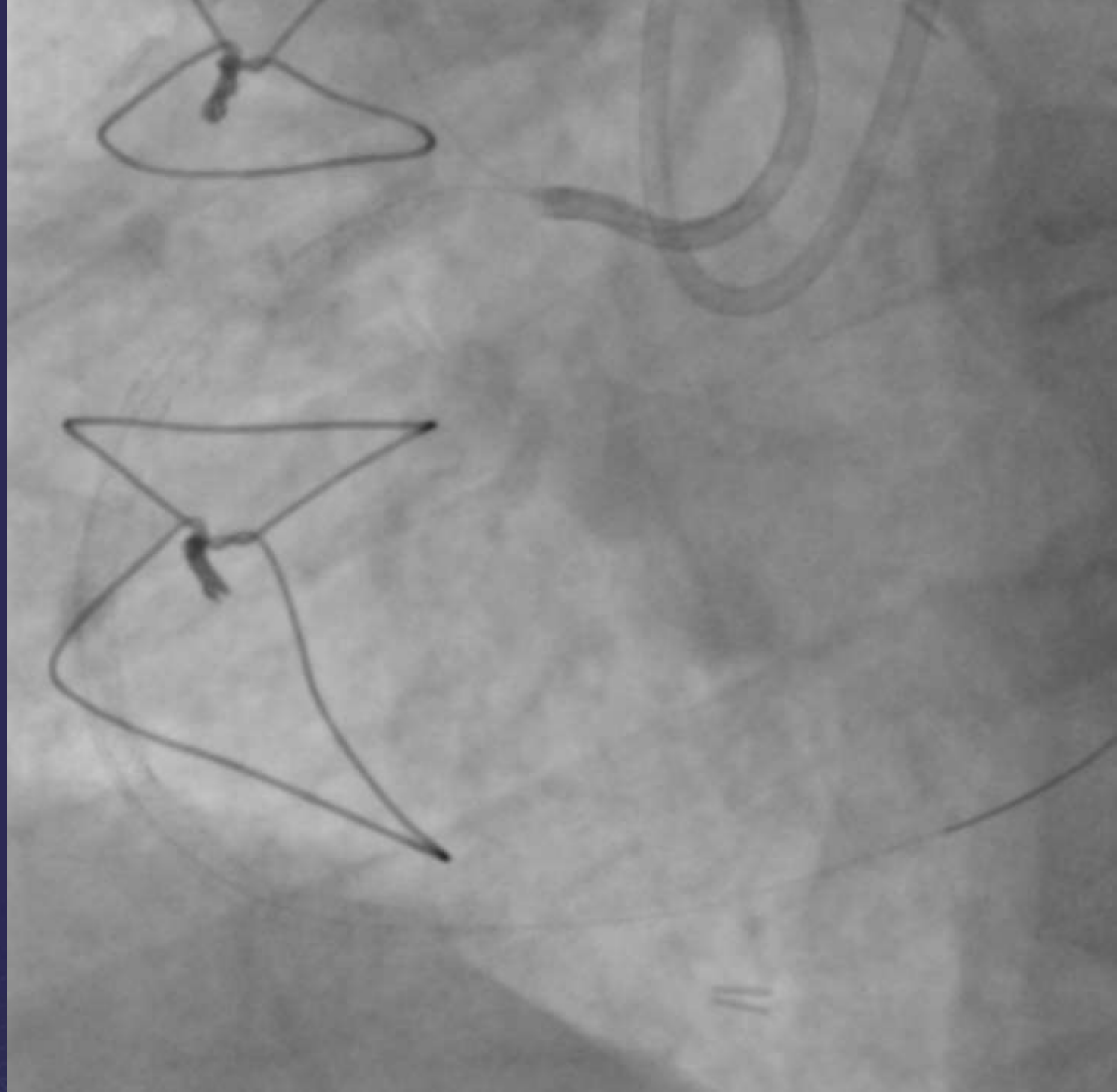
CTO Case

- GAIA 3rd Next advanced easily into distal vessel with no resistance
- LAO cranial confirming wire is in distal true lumen



CTO Case

Final result following placement of 3.5 x 38 and 3.5 x 32 mm Synergy stents



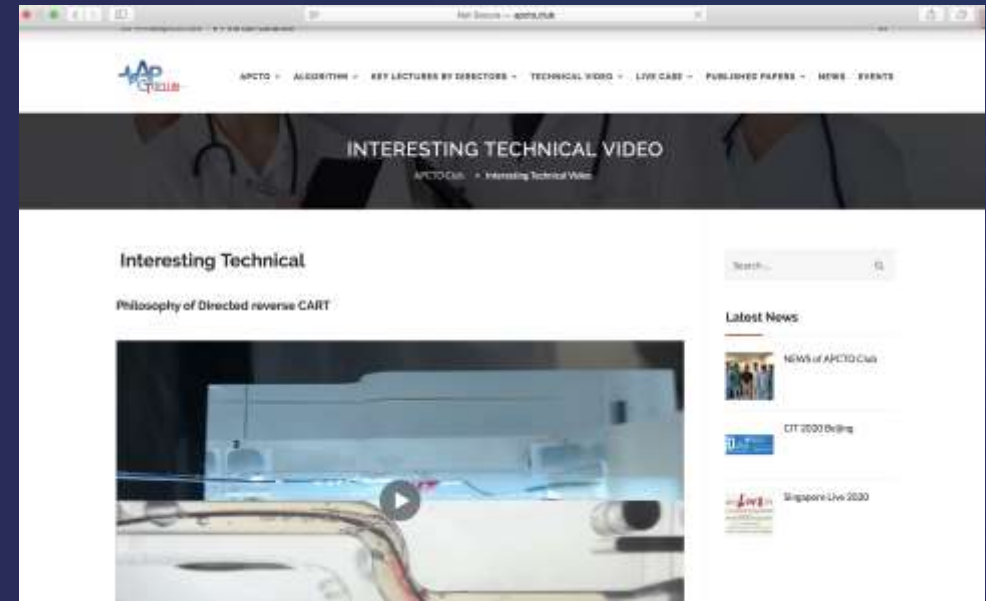
DISCUSSION III

- ADR can be a good alternative to retrograde in suitable cases
- ADR has evolved and can be performed through radial route with 7Fr or even 6F guide catheters and without CrossBoss or the Stingray wire

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Nice pictures
Live cases
&
Technical Videos
It's all here!!



Algorithms and methods

